Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SOUTH COAST SPINE & REHAB PA 620 PEREDES LINE ROAD BROWNSVILLE TX 78521	MFDR Tracking #: M4-07-6711-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: BROWNSVILLE ISD Box #: 29	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Per Rule 133.1(8) this is our usual and customary charge for a 6 oz tube of Biofreeze that effectively helps relieve [claimant] pain without the need for therapy. This supply cannot be included in the allowance for another service." "Per Rule 133.1(8) this is our usual and customary charge for a Home Exercise Kit that maintain & further enhance [claimant] range of motion without the need for therapy. This supply cannot be included in the allowance for another service."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Total Amount Sought - $60.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
11/14/2006	A4558	$4.63 X 125% = $5.79	$10.00	$5.79
	A9300	Not Applicable	$50.00	$0.00
			Total Due:	$5.79

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on June 11, 2007.
2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
3. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.

4. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment and services.
5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
6. Division rule at 28 TAC §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 12/26/2006

   - 97TX-Payment is included in the allowance for another service/procedure.
   - B291TX-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.

Issues

1. Did the carrier support the denial reason code?
2. What is the applicable rule for reimbursement?
3. Did the requestor support the position that reimbursement is due for HCPCS code A4558 and A9300?
4. Is the requestor entitled to additional reimbursement?

Findings

1. On the disputed date of service, the requestor billed CPT codes 99213, A4558 and A9300. The respondent paid for the office visit coded 99213 and denied reimbursement for A4558 and A9300 based upon "97TX." A review of the submitted documentation indicates that "The patient was issued a body elastic home exercise kit in order to maintain further & enhance the in current strength and range of motion…An instructional video displaying proper usage of the Bodylastics kit was included to reinforce the doctor's explanation." "Biofreeze is a unique, effective analgesic formulated to provide a variety of benefits for therapy, pain relief, exercise/training, and overall comfort." These supplies were given to the claimant for home use, not for use during the office visit; therefore, they are not incidental to or included in the office visit. The respondent did not submit documentation to support the denial reason. These services will therefore be reviewed per applicable payment guidelines.
2. Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Division rule at 28 TAC §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program methodologies, models, and values or weight including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."

   - HCPCs code A4558 is described as "Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz". Per DMEPOS, HCPCS code A4558 has a fee of $4.63.
   - HCPCS code A9300 is described as "Exercise equipment." Neither the DMEPOS fee schedule nor the Texas Medicaid Fee Schedule has set a fee for HCPCS code A9300.

   Division rule at 28 TAC §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based

on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The Division finds that HCPCS codes A9300 does not have an established relative value and the insurance carrier did not submit documentation to support that the carrier has assigned a relative value.

Division rule at 28 TAC §134.202(d) states "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated and/or contracted between the provider and carrier for the disputed HCPCS code A9300; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate in accordance with Division rule at 28 TAC §134.1.

2. Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's rationale for increased reimbursement states that "Per Rule 133.1(8) this is our usual and customary charge for a Home Exercise Kit that maintain & further enhances (claimant) range of motion without the need for therapy. This supply cannot be included in the allowance for another service."
   - The requestor does not discuss or explain how payment of $50.00 would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor did not submit nationally recognized published relative value studies, published commission medical dispute decisions, or values assigned for services involving similar work and resource commitments.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

   The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for HCPCS codes A9300. As a result the amount ordered is $0.00.

3. Reimbursement will be as follows for HCPCS codes A4558:
   - Per DMEPOS, HCPCS code A4558 has a MAR of $4.63. This amount multiplied by 125% = $5.79. This amount minus previously paid of $0.00 = $5.79. This amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor for HCPCS code A4558. For the reasons stated above, the division finds that the requestor has established that reimbursement is due for HCPCS code A4558. As a result, the amount ordered is $5.79.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $5.79 reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $5.79 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**July 9, 2010** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.